Workers' Compensation
Low Back Examination

Please return completed application to the applicable entity regarding this claim.
(Private Carrier, Self-Insured, or Third Party Administrator (TPA) administering this claim)

USE BLACK INK *To Be Completed by the Physician* *Page 1*

Patient Name: _____
SSN: __ __ __ - __ __ - __ __ __ __ **HT.** _____
Date of Injury: __ __ / __ __ / __ __ **WT.** _____
Date of Birth: __ __ / __ __ / __ __ **Pulse** _____
Claim Number __ __ __ __ __ __ __ __ __ **BP** _____
Date of Exam: __ __ / __ __ / __ __ **Resp.** _____

Physician: _____
Address: _____
_____
Phone: _____
FEIN: __ __ __ __ __ __ __ __ __ __ __ __ __

PLEASE CHECK ONE OR MORE:

☐ **CLAIM REOPENING** ☐ **IMPAIRMENT RATING** ☐ **120-DAY EXAMINATION**
☐ **CONSULTATION** ☐ **INDEPENDENT EXAMINATION** ☐ **COMPREHENSIVE EXAMINATION**

1. INSPECTION *(standing)*

	YES	NO	
1.1 Patient stands unassisted	☐	☐	_____
1.2 Scoliosis	☐	☐	_____
1.3 Antalgic lean *(Asymmetry)*	☐	☐	_____
1.4 Lumbar Hypolordosis	☐	☐	_____
1.5 Lumbar Hyperlordosis	☐	☐	_____

Other observations: _____

2. PALPATION *(standing, seated, or prone)*

	YES	NO	
2.1 Vertebral tenderness/restriction	☐	☐	☐ **L1** ☐ **L2** ☐ **L3** ☐ **L4** ☐ **L5**
2.2 Coccyx tenderness (external palpation)	☐	☐	_____
2.3 Sacral base & pelvis level (standing)	☐	☐	_____

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	☐	☐	☐	☐	
2.5 Paraspinal muscle spasm	☐	☐	☐	☐	_____
2.6 Sacroiliac joint tenderness	☐	☐	☐	☐	_____

3. GAIT

3.1 Limp ☐ Yes ☐ No ☐ Left ☐ Right Explain _____
3.2 Assistive devices *(cane, brace, prosthesis)* _____
3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty Yes No
Comments_____

5. RANGE OF MOTION (standing)*****

		WNL	PAIN	RESTRICTION
5.1 Sacral Flexion	___°	☐	☐	☐
5.2 Sacral Extension	___°	☐	☐	☐
5.3 Forward bending *(Flexion)*	___°	☐	☐	☐
5.4 Backward bending *(Extension)*	___°	☐	☐	☐
5.5 Left side bending	___°	☐	☐	☐
5.6 Right side bending	___°	☐	☐	☐

5.7 Comments _____
5.8 Inclinometer ☐ Yes ☐ No **(Inclinometer required for impairment examinations)**

***NOTE: Subtract sacral motions from T12 motions (pp.3/126-129 AMA Guides, 4th ed.)**

RANGE OF MOTION CERTIFICATION

Thoracolumbar motion testing is valid if the following four criteria are achieved. Please certify the status of the examinee on each of these four criteria:

•The back injury is now stable. □Yes □No
•The motions were not curtailed due to a report of pain, fear of injury, or neuromuscular inhibition. □Yes □No
•Three consecutive measurements of each motion were within 5° (within 10° if the three averaged 50° or more) □Yes □No
•Examinee passed validity test. □Yes □No

Physician's Signature

Source: AMA Guides to the Evaluation of Permanent Impairment, pp. 112 & 127.

Patient's Name _____ **Date of Exam** _____ **Claim Number** _ _ _ _ _ _ _ _ _ _

6. MOTOR STRENGTH *(standing, walking, seated, or supine)* **GRADE (OUT OF 5)**

	NORMAL	ABNORMAL	LEFT	RIGHT
6.1 Hip flexion	☐	☐	_____	_____
6.2 Hip extension	☐	☐	_____	_____
6.3 Hip abduction	☐	☐	_____	_____
6.4 Knee extension	☐	☐	_____	_____
6.5 Knee flexion	☐	☐	_____	_____
6.6 Ankle dorsiflexion	☐	☐	_____	_____
6.7 Ankle planter flexion	☐	☐	_____	_____
6.8 Great toe extension	☐	☐	_____	_____
6.9 Heel toe walk	☐	☐	_____	_____
6.0 Toe walk	☐	☐	_____	_____

7. SENSORY *(pin prick) (seated or supine)*

	LEFT			RIGHT		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	☐	☐	☐	☐	☐	☐
7.2 L4 sensory	☐	☐	☐	☐	☐	☐
7.3 L5 sensory	☐	☐	☐	☐	☐	☐
7.4 S1 sensory	☐	☐	☐	☐	☐	☐

7.5 Comments _____

8. REFLEXES *(seated) (+2normal)*

Patellar	8.1 Left	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
	8.2 Right	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
Achilles	8.3 Left	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
	8.4 Right	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus

Other _____

9. STRAIGHT LEG RAISING *(sitting) (0-90° scale)*

(Measure knee extension)

9.1 Left _____ ° **Pain:** ☐ Yes ☐ No **Location of Pain:** ☐ Back ☐ Same Leg ☐ Contralateral back/leg

9.2 Right _____ ° **Pain:** ☐ Yes ☐ No **Location of Pain:** ☐ Back ☐ Same Leg ☐ Contralateral back/leg

10. HIP AND SACROILIAC TESTS

10.1 Hip test pain ☐ Yes ☐ No ☐ Left ☐ Right

10.2 Sacroiliac test pain ☐ Yes ☐ No ☐ Left ☐ Right

11. STRAIGHT LEG RAISING *(supine) (0-90° scale)*

11.1 Left _____ ° **Pain:** ☐ Yes ☐ No **Location of Pain:** ☐ Back ☐ Same Leg ☐ Contralateral back/leg

11.2 Right _____ ° **Pain:** ☐ Yes ☐ No **Location of Pain:** ☐ Back ☐ Same Leg ☐ Contralateral back/leg

12. PULSES

	LEFT		RIGHT	
12.1 Dorsalis Pedis _____ Present?	☐ Yes	☐ No	☐ Yes	☐ No
12.2 Posterior tibial _____ Present?	☐ Yes	☐ No	☐ Yes	☐ No

12.3 Other observations *(Clubbing, Cyanosis)* _____

13. MUSCLE MEASUREMENT

13.1 Left Thigh _____ Right Thigh _____ _____ cm below tibial tubercle

13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical ☐ Yes ☐ No ☐ Not Tested

14.2 Shorter ☐ Left ☐ Right ☐ Supine ☐ Standing

Difference of (cm) _____ Right (cm) _____ Left (cm) _____

□ **Supine:** measure from anterior superior iliac spine to medial/lateral malleolus.

□ **Standing:** measure from greater trochanter to floor

Patient's Name _____ **Date of Exam** _____ **Claim Number** _ _ _ _ _ _ _ _ _ _

15. OTHER TESTS AND FINDINGS _____

_____

_____

_____

_____

16. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION **SCORE** _____

SENSORY EXAMINATION: RESPONSE TO PINPRICK (check)

16.1 No deficit or deficit well localized to dermatome(s)
Deficit related to dermatome(s) but some inconsistency
Nondermatomal or very inconsistent deficit
Blatantly impossible *(i.e., split down midline of entire body with positive tuning fork test)*

16.2 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐

MOTOR EXAMINATIONS (check)

16.3 No deficit or deficit well localized to myotome(s)
Deficit related to myotome(s) but some inconsistency
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling
or giving away, weakness is coachable
Blatantly impossible, significant weakness which disappears when distracted

16.4 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐

TENDERNESS (check)

16.5 No tenderness or tenderness localized to anatomically sensible structure
Tenderness not well localized, some inconsistency
Diffuse or inconsistent tenderness, multiple structures *(skin, muscle, bone, etc.)*
Impossible, significant tenderness of multiple structures *(skin, muscle, bone, etc.)*
which disappears when distracted

16.6 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐

DIFFERENTIAL STRAIGHT LEG RAISING (SLR)

16.7 The difference between SLR tests performed in the supine and sitting positions *(the patient is distracted in the sitting position by examining the bottom of his/her feet).* Example: supine SLR positive at 10°, seated SLR positive 50°, difference = 40° (check)
Difference <20° 0 ☐ 20-45° 1 ☐ >45° 2 ☐
No pain seated, but strongly positive SLR when supine at less than 45° 3 ☐

TOTAL SCORE: _____

17. COMMENTS _____

_____

_____

_____

_____

Patient's Name _____ **Date of Exam** _____ **Claim Number** _ _ _ _ _ _ _ _ _ _

18. RADIOGRAPHIC EXAM ☐ Yes ☐ No Date _____ Type *(Plain, CT, MRI, Myelogram)*_____

Findings *(Attach report if available)*: _____

_____

_____

Patient Position During X-ray: ☐ Recumbent ☐ Weight Bearing ☐ Unknown

19. CLINICAL DIAGNOSIS

(Please indicate appropriate ICD-9 code(s) and give written description. Generic diagnoses are printed for your convenience; you may substitute other diagnoses. If appropriate, multiple diagnoses can be designated.)

SOFT TISSUE

- ☐ Lumbar sprain/strain (847.2)
- ☐ Lumbosacral sprain/strain (846.0)
- ☐ Sacroiliac sprain/strain (846.1)

POSTERIOR JOINTS

- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation (839.20) or segmented dysfunction (739.3) (circle)

DISC

- ☐ Lumbar disc displacement without myelopathy *(with or without radiculitis)* (722.10)
- ☐ Lumbosacral radiculitis (724.4)

SACROILIAC

- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation (839.42) or segmental dysfunction (739.4) (circle)

OTHER: _____

_____

_____

20. RECOMMENDATIONS, OPINION, REFERRALS, TX PLAN OR REDIRECTION: _____

_____

_____

_____

_____

_____

_____

_____

21. AUTHORZATION(S) REQUESTED FOR: _____

_____

_____

_____

22. PHYSICIAN'S SIGNATURE _____ **DATE**_____

Workers' Compensation
Patient History – Back Pain

USE BLACK INK

To Be Completed by Office Staff

Patient Name: _____
SSN: __ __ __ - __ __ - __ __ __ __
Date of Injury: __ __ / __ __ / __ __
Date of Birth: __ __ / __ __ / __ __
Claim Number __ __ __ __ __ __ __ __
Date of Exam: __ __ / __ __ / __ __

PHYSICIAN MUST SUBMIT THIS FORM WITH LOW BACK EXAM

Physician: _____
Address: _____
_____
Phone: _____
FEIN: __ __ __ __ __ __ __ __ __ __ __

TO BE COMPLETED BY PATIENT (ASSISTANCE PERMITTED)

Present History

1. What are your problems? _____
_____
_____

2. How did the problem occur? _____
_____
_____

3. Where is the location of the problem/pain? _____
_____
_____

4. Have you had this type of complaint before? □Yes □No
When? Where? _____
_____
_____

4.1 How did that earlier complaint occur?
_____
_____

5. What is the name of your employer?
_____

5.1 What is the type of business of that company?
_____

5.2 What was your job title when the problem began?
_____
_____

5.3 What was your usual job? *(Job Tasks)*
_____
_____

5.4 Describe your job tasks. _____
_____
_____

5.5 What job were you performing when problem began?
_____
_____

6. Who is your immediate supervisor?

_____
Name Phone Number

7. Have you discussed your problem with your supervisor?
☐ Yes ☐ No

8. Is there modified or alternative work at your job?
☐ Yes ☐ No ☐ Don't Know

8.1 Are you now working? ☐ Yes ☐ No

8.2 If yes, employer _____

8.3 If yes, your job title _____

9. Your pain is worse in your:

☐ Head	☐ Left Arm	☐ Right Hip
☐ Neck	☐ Right Arm	☐ Left Leg
☐ Left Shoulder	☐ Back	☐ Right Leg
☐ Right Shoulder	☐ Left Hip	

☐ Other _____

10. Your problem/pain is:

	Better	Worse	No Different
When you urinate or move your bowels	☐	☐	☐
When coughing or sneezing	☐	☐	☐
When you wake up in the morning	☐	☐	☐
In the middle of the night	☐	☐	☐
Mid-day	☐	☐	☐
Evening	☐	☐	☐
Lying	☐	☐	☐
Sitting	☐	☐	☐
Driving	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Change of position	☐	☐	☐

11. Have you been treated for this complaint before now?
☐ Yes ☐ No Where? _____

12. What has helped this complaint the most? _____
_____

13. What has helped or made this complaint worse?
_____

14.1 Do you get pain at the tip of your tailbone? ☐ Yes ☐ No
14.2 Does your whole leg ever become painful? ☐ Yes ☐ No
14.3 Does your whole leg ever go numb? ☐ Yes ☐ No
14.4 Does your whole leg ever give way? ☐ Yes ☐ No
14.5 In the past year, have you had any spells with very little pain? ☐ Yes ☐ No
14.6 Have you had any intolerance to your treatment or reaction to treatment? ☐ Yes ☐ No
14.7 Have you had an emergency room visit with back trouble since your recent work injury? ☐ Yes ☐ No

Patient's Name_____ **Date of Exam** _____ **Claim Number** __ __ __ __ __ __ __ __ __ __

Past History

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
    X-ray ☐ Yes ☐ No
    When/Where/Results _____
    MRI ☐ Yes ☐ No
    When/Where/Results _____
    CT scan ☐ Yes ☐ No
    When/Where/Results _____
    Myelogram ☐ Yes ☐ No
    When/Where/Results _____

16. Have you ever been hospitalized for neck, arm, back, hip, or leg complaints/pain? ☐ Yes ☐ No
    Which/When/Where_____
    _____

17. What other medical problems do you have?
    ☐ Heart, blood pressure, or circulation problems (circle)
    ☐ Diabetes ☐ Gout
    ☐ Arthritis ☐ Cancer
    ☐ Other _____
    _____

18. Have you been hospitalized for any of the above problems? ☐ Yes ☐ No
    Which/When_____

19. What medicines are you now taking, including over-the-counter?
    _____
    _____
    _____
    _____
    _____

20. Do you have a family doctor? ☐ Yes ☐ No
    Name: _____
    Phone No: _____

21. Allergies to food, medicine or other? ☐ Yes ☐ No
    List: _____
    _____
    _____

22. Do you smoke, rub, or chew tobacco? ☐ Yes ☐ No

23. Do you drink beer, wine or liquor? ☐ Yes ☐ No
    How Much? _____

23.1 Ever had an alcohol problem? ☐ Yes ☐ No

24. Do you drink coffee or tea or caffeine drinks? ☐ Yes ☐ No
    How much per 24 hours? _____

25. How much formal education do you have?
    ☐ College or higher *(specify)* _____
    ☐ Vocational Training
    ☐ High School Diploma
    ☐ GED
    ☐ Grade Completed _____

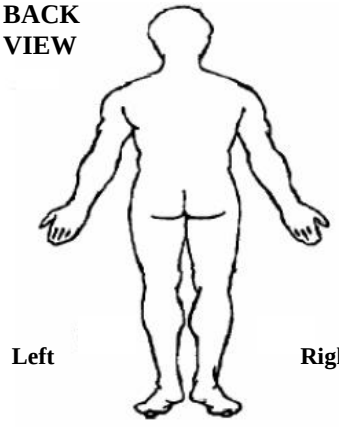
26. Do you have other family members with serious back or neck problems? ☐ Yes ☐ No
    Are they disabled? ☐ Yes ☐ No

27. Any additional comments:
    _____
    _____
    _____
    _____
    _____

Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition. **Draw in your face:**

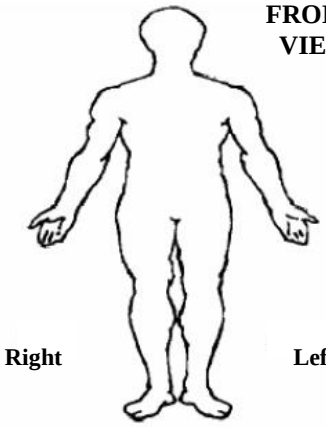
KEY:
Stabbing / / /
Burning X X X
Pins And Needles O O O
Aching, Throbbing ^ ^ ^
Numbness = = =
Other • • •

BACK VIEW



Left **Right**

FRONT VIEW



Right **Left**

Signature of person completing form _____ **Date** _____
If signature is not of patient, then state relationship to patient _____